

Case Studies

of EXEMPLARY PRIMARY CARE
PRACTICE FACILITATION
TRAINING PROGRAMS

Training Program
Summary:
Practice Coach Training for
the North Carolina AHEC
Practice Support Program



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CASE STUDIES OF EXEMPLARY PRIMARY CARE PRACTICE FACILITATION TRAINING PROGRAMS

As part of its ongoing commitment to practice improvement, the Agency for Healthcare Research and Quality has developed resources and products to support the use of practice facilitation in primary care settings (www.pcmh.ahrq.gov/page/practice-facilitation). A growing body of evidence indicates that practice facilitation, which is based on the creation of an ongoing, trusting relationship between an external facilitator and a primary care practice, is an effective strategy to improve primary health care processes and outcomes. Practice facilitation activities may focus in particular on helping primary care practices become patient-centered medical homes, but they can also help practices in more general quality improvement and redesign efforts.

As part of its work in this area, AHRQ commissioned Mathematica Policy Research to conduct case studies of three exemplary practice facilitation training programs in the United States and describe their formation, operation, and curricula. The three programs, which vary in location, administrative homes, and organizational and training models, were selected based on results of an environmental scan of existing practice facilitation training programs and nominations from the field.

We hope that these case studies will be useful to groups and individuals who are developing or improving primary care practice facilitation programs; trainers and students in existing programs; and other members of the primary care community, including clinicians and policymakers.

We are deeply grateful to the case study participants from the three exemplary programs for their time and significant contributions to this work:

Health TeamWorks Coach University

Marjie Harbrecht, M.D., Chief Executive Officer, HealthTeamWorks

Jennifer Snyder, R.N., M.S.H.S., NEA-BC, Regional Director - East Coast, HealthTeamWorks

Kelly Bowland, M.S.M., Education and Training Manager/Quality Improvement Coach, HealthTeamWorks

Ballard Pritchett, M.B.A., Sales and Marketing Consultant and Strategist, HealthTeamWorks

Millard Fillmore College Practice Facilitator Certificate Program

Larry Gingrich, Associate Dean, The State University of New York at Buffalo, Millard Fillmore College

Lyndee Knox, President, L.A. Net Community Health Resource Network

June Levine, Instructor - Practice Facilitator Certificate Program, The State University of New York at Buffalo, Millard Fillmore College

Diana Anderson, Practice Enhancement Assistant at The State University of New York at Buffalo, Department of Family Medicine

Deborah Kane, Program Manager, The State University of New York at Buffalo, Millard Fillmore College

Jeremiah Grabowski, Online Programs Coordinator, The State University of New York at Buffalo, School of Public Health and Health Professions

Chester Fox, Professor of Family Medicine, The State University of New York at Buffalo, Department of Family Medicine

Practice Coach Training for the North Carolina AHEC Practice Support Program

Ann Lefebvre, M.S.W., CPHQ, Associate Director, Statewide Quality Improvement, NC AHEC Program, University of North Carolina at Chapel Hill

Training Program Summary: Practice Coach Training for the North Carolina AHEC Practice Support Program

Strong training is essential for developing effective practice facilitators (PFs) to support improvements in primary care practices. This case study profiles the practice facilitator (called practice coach) training of the North Carolina Area Health Education Center (AHEC) Practice Support Program (PSP). Available only to staff of the North Carolina AHEC PSP, the training program prepares practice coaches to serve on regional practice facilitation teams that work with primary care practices to improve quality of care, transform to patient-centered medical homes (PCMHs), implement electronic health records (EHRs), and attain meaningful use certification.¹

Practice coaches specialize in one of three areas—quality improvement (QI), data acquisition and reporting, or EHR implementation—and work together on facilitation teams in one of nine AHEC regions in the State. The North Carolina AHEC PSP has trained a total of 70 practice coaches since 2006. Training forms the heart of the State’s AHEC PSP and is intensive and continuous. Coaches participate in weekly to biweekly virtual training, on-site training, tandem field experiences, and peer-to-peer learning. In addition, they have access to an online resource library and a secure listserv. Coaches are trained in 49 coaching competencies, and training content is continually updated to keep coaches well prepared to help practices respond to emergent needs in the field.

The North Carolina AHEC PSP has trained a total of 70 coaches since 2006. Training is intensive and continuous. It includes weekly to biweekly virtual trainings, on-site trainings, field experiences, peer-to-peer learning, an online resource library and a secure listserv.

The North Carolina AHEC PSP training strategy offers several lessons for others interested in developing and delivering PF training:

- ▲ Training should be continuous and intensive and should have a means for identifying emergent issues in the field and preparing practice coaches to address them.
- ▲ As coaches come from a variety of backgrounds, training should be tailored to meet each learner’s needs.
- ▲ Coaches should be trained first in the topics that are of the highest urgency and the most important to their practices to ensure that they can be immediately useful to their practices.
- ▲ Training should include a robust apprenticeship with an experienced practice coach. Ideally the apprenticeship should take place in the practices that the trainee will eventually support.

¹ A 2013 AHRQ case study describes the North Carolina AHEC PSP program in depth and can be accessed at: http://pcmh.ahrq.gov/sites/default/files/attachments/NorthCarolina_020413comp_0.pdf

I. Background and motivation

The North Carolina AHEC Practice Support Program has provided support to 1,100 primary care practices in North Carolina. Its focus is on helping primary care practices to improve quality and transform to PCMHs. The North Carolina AHEC PSP also houses the North Carolina Health Information Technology Regional Extension Center (HITREC), which aids practices in selecting and implementing EHRs and attaining meaningful use certification.

The North Carolina AHEC PSP program began in 2006 as a pilot program as part of the Improving Performance in Practice initiative. Program staff consisted of two practice coaches who supported a total of 16 practices. The results of the pilot were so encouraging that the State of North Carolina funded an expansion of the program to all nine AHEC regions of the State. This necessitated a scale-up plan that included practice recruitment and preparation of new facilitation teams for each region. At this point, program staff consisted of only one practice coach; that individual is now director of the statewide program. To accomplish the scale-up, the director began with a single region and then moved sequentially to each of the remaining regions, until a core of approximately 10 primary care practices had been recruited and a facilitator had been deployed in each region.

To recruit the start-up practices, the director reached out to practices and stakeholder groups, like Community Care of North Carolina, in each AHEC region. Once practices had been identified, the director began active facilitation work in these practices. Concurrent with this, she also began recruiting and training members of the facilitation team for the region. Teams included an expert in QI and an expert in data. When the PSP was expanded to include the State's HITREC, experts in EHR implementation were added to each team.

To prepare these staff to work with practices and as facilitators, the director had the individuals serve as apprentices with her as she worked with the start-up practices. Once she thought the team members were sufficiently trained and that facilitation intervention was solidly underway in a practice, she turned over leadership of the intervention to the newly trained personnel. The director then moved to the next AHEC region, beginning the process over again until she reached all nine regions.

In explaining the intensity of effort required for this initial scale-up, the director half-jokingly explained that she measured her progress by how many oil changes she had to make to her car each month.

II. High-level design

Currently, the North Carolina AHEC PSP training is only for program staff and is designed to prepare individuals as practice coaches to serve on the program's PF teams located in each of the State's AHEC regions. Facilitation teams include experts on QI, data acquisition and reporting, and EHR implementation. Training prepares individuals with these differing areas of expertise to work with their fellow facilitators and practices. The training helps each trainee develop his or her particular area of expertise while acquiring a basic understanding of change management and QI methods.

Training is continuous throughout a facilitator's tenure with the North Carolina AHEC PSP and combines didactic, peer-to-peer, and experiential learning. Instruction is tailored to the specific

learning needs of each staff member, and new content is continually being added in response to requests from team members to address emergent needs of the practices. The majority of the training takes place virtually to allow facilitation teams from across the State to participate, but there are at least two and sometimes more in-person training sessions each year. Training also includes access to a learning community of facilitators and a very active internal listserv that team members use to share ideas and best practices.

III. Program description

Program elements. The North Carolina AHEC PSP training consists of eight elements: (1) orientation for new hires, (2) tandem site visits, (3) biweekly training on general coaching skills, (4) as-needed training on new or priority topics, (5) in-person training conferences, (6) daily use of a secure listserv for coaches to exchange ideas and best practices and share emergent issues in the field, (7) a Web-based library of coaching resources, and (8) access to the program director and her staff for individualized assistance and problem solving as needed.

The program combines didactic, peer-to-peer, and experiential learning and is grounded in adult learning theory.

Coaches are expected to develop competencies appropriate to their specific area of expertise on their facilitation team. All coaches, regardless of their area of expertise, are expected to learn basic change management and project management processes.

Orientation. Orientation lasts 1 day and takes place at the North Carolina AHEC PSP offices. New hires learn about the PSP's mission, coaching approach, and improvement packages (a structured series of activities that coaches are expected to facilitate at their practices to attain improvements in particular areas). Orientation is offered twice yearly, or more frequently if needed. One to 20 students participate, based on the number of new hires at the time of the training.

Tandem site visits. New hires complete site visits to the practices they will eventually support in tandem with a facilitator who is already working with the practices. During these visits, the new coach meets people at the practices, learns about the improvement work currently being conducted, and also meets individuals from the larger medical community.

Twice-monthly training Webinars. All practice coaches participate in biweekly training calls led by the program director or the QI manager. These 1- to 2-hour-long meetings focus on skill building in the 49 core coaching competencies and on peer-to-peer learning. They also provide an opportunity for the coaches to alert the director and her staff to new developments in the field or training needs that they would like addressed during future training sessions. Facilitation teams from each region are expected to host at least one Webinar a year. During these sessions, the teams share approaches and resources that are working well in their practices as a method of sharing best practices.

Emergent issues training Webinars. In addition to standard biweekly training calls, practice coaches may also participate in virtual training sessions on emergent issues. These training sessions, called "office hours," are focused on emergent issues in the field such as new State or Federal regulations or payer initiatives. The training director is also currently holding biweekly calls on meaningful use Stage 2 standards to prepare the coaches to support their practices in this area. During these calls, coaches can

also register questions they or their practices have about the given topic, and the director and her staff will provide training on these topics on future calls.

Training conferences. In-person 2-day training conferences take place twice a year and are mandatory for all practice coaches. The conferences focus on filling gaps in knowledge and skills identified through an annual coach self-assessment. Coaches share best practices with each other during these sessions and problem solve areas that are not working. The director and staff use information shared in this peer-to-peer learning to inform development of future training sessions and to improve the services provided to practices by the PSP.

Listserv and secure Web site. The secure coach listserv is an important part of the North Carolina AHEC PSP training. The listserv, which is open only to practice coaches and support staff in the program, provides a forum for coaches to ask questions of their colleagues, report problems in the field, and share information about resources and effective methods. It also provides a place for coaches to share frustrations and request support from each other. Because practice coaches often work in isolation from each other for substantial periods of time, the listserv functions as a virtual community for them or, as the director describes it, as a “virtual water cooler.” The listerv is very active, with 20 or more posts a day. A librarian tags and uploads key information from the posts to a secure searchable Web site, thus creating a knowledge resource that coaches can access and use as needed.

Professional development. PSP coaches are also encouraged to attend a QI 101 workshop offered through the NC AHEC program, to use the Institute for Healthcare Improvement’s (IHI’s) Open School, and to access other professional development offerings through national conferences and training programs.

Program content. The North Carolina AHEC PSP training instructs practice coaches on 49 core coaching competencies, as well as on emergent issues identified from the field. The core competencies fall into six categories:

- ▲ **Program mission and methods.** Orients the student to the North Carolina AHEC’s mission and model, the PSP mission and model, and elements of the PSP training and knowledge management systems.
- ▲ **Clinical improvement consulting.** Focuses on the structure and processes of primary care and on basic skills in QI coaching.
- ▲ **Practice system redesign and innovation.** Focuses on the chronic care model and on training practice coaches to use the different change methods (structured intervention processes) for improving patient care.
- ▲ **PCMH recognition.** Trains coaches in assisting practices applying for recognition.
- ▲ **EHR incentive program consulting.** Includes knowledge and skills for helping practices implement and optimize EHR systems and attain meaningful use certification.
- ▲ **Practice management consulting.** Trains practice coaches on issues such as payment reform, improved coding, and business models focused on improved quality.

New content is continually being added in response to requests from practice coaches and to address emergent needs of the practices.

For each competency, four levels of proficiency are possible: (1) the ability to describe the topic to a practice, (2) the ability to explain the program or topic to the practice and refer the practice to additional resources, (3) the ability to demonstrate the target skill or knowledge and use it with the practice, and (4) the ability to teach a practice the target skill or knowledge and facilitate use by practice staff.

Staff are expected to attain the level of proficiency established by the program for each competency. In some instances, practice coaches need only attain the first degree of proficiency. In other instances, they are expected to attain the fourth level. A list of competencies, with the target proficiency level noted, is provided in the Appendixes.

Coach assessment. Practice coaches complete a self-assessment of their skills and knowledge of the 49 core coaching competencies when they enter the training and annually thereafter. The program director and her staff use these assessments to plan tailored training and to identify coaches with sufficient expertise to serve as faculty.

Training delivery. Training is delivered using video conferencing Webinars, in-person meetings, and a listserv. Video conferencing makes it possible for all practice coaches to participate in training regardless of their location. It also makes the training more cost-effective. Sessions are recorded and made available online to coaches who are unable to attend the live sessions. In-person training occurs twice a year and takes place at the program's central offices at the University of North Carolina at Chapel Hill. Although it is more expensive, in-person training is seen as vital to the cohesiveness of the program. These sessions give coaches an opportunity to connect with each other, and give coaches and trainers time to explore best practices in greater depth than is possible using virtual meetings. The program's listserv gives coaches a way to communicate and exchange ideas on a daily basis. This is an important part of coach training as well as support. The listerv is maintained through the program's administrative office. It and the Web-based resource library are part of the comprehensive information management and data reporting systems designed for the program by faculty from the University of North Carolina at Chapel Hill.

Methods of instruction. Training includes didactic instruction, self-study using online resources, peer-to-peer learning, and field experience. Didactic instruction makes up a large portion of the virtual and in-person training sessions. All practice coaches are asked to complete self-study modules on basic quality improvement through IHI's Open University. Peer-to-peer learning takes place during didactic sessions, since each regional team leads at least one session each year and shares lessons learned; through interactive discussions during Webinars; and through daily use of the listserv. Field instruction is conducted in sites where the learner will be working and occurs most frequently as an apprenticeship with a more experienced coach.

In a team approach to facilitation, coaches need to be proficient in their particular area of expertise but do not need to be proficient in every competency.

Duration and intensity. Each coach participates in an estimated 108 hours of virtual training and 32 hours of in-person training each year. New hires complete an additional 8 hours of in-person training. In addition, coaches participate in daily peer-to-peer learning and support through the program's listserv.

IV. Trainees

The number of staff participating in training ranges from 9 to 50, depending on the number of coaches employed by the program at the time. Practice coaches come from a variety of backgrounds, including public health, health administration, social work, nursing, and psychology. To be hired by the program, an individual must have worked in health care, preferably in ambulatory care. Most coaches hold a master's degree, and many come to coaching as a second career.

V. Faculty and trainers

The program director and QI manager serve as primary faculty for training practice coaches. In addition, the program is in the process of adding a health information technology (IT) manager to further support and develop training in meaningful use of health IT. In addition, outside experts (typically physicians selected for their expertise in QI and transforming health care processes and systems) provide training on a variety of topics. Most of these experts come from a university in North Carolina. The Carolinas Center for Medical Excellence provides EHR adoption training for new staff. The program also relies on its partnerships with the State health information exchange, Community Care of North Carolina, payer organizations, public health agencies, and other entities to identify experts to provide support and training. The use of outside faculty members is seen as building credibility for the program in the guest faculties' communities and increases the visibility of the program across the State.

Outside faculty are important resources for a PSP. Not only do they provide training to coaches, but they can also serve an important public relations function for the PSP.

VI. Program administration

Staffing. The North Carolina AHEC PSP director serves as the training director. She spends 20 percent of her time working with the training program and is responsible for administering the training as well as serving as faculty. A QI manager spends 60 percent of her or his time on teaching QI methods, producing curriculum, and disseminating specific QI resources. A health IT manager will spend 60 percent of his or her time training practice coaches on meaningful use and EHR use. He or she will produce training materials and dissemination packages for coaches on successful health IT improvement efforts. A full-time librarian supports both the overall PSP program and coach training by monitoring and tagging listserv content, maintaining an online resource center of training and improvement tools for the coaches, scanning key publications for pertinent information to include in training, and preparing curricula. All staff members continuously monitor and respond to questions from coaches on the listserv and field phone calls from coaches needing information and resources.

Funding. No tuition is collected from staff. Costs of training are covered by incorporating them into contract and grant budgets when possible, through philanthropic gifts, and through contracts with payers.

VII. Evaluation and internal QI of the training

The North Carolina AHEC PSP does not formally evaluate training efforts. They acknowledge they would like to do this in the future.

VIII. Outcomes and placements

The North Carolina AHEC PSP has trained 70 practice coaches. Training takes place concurrently with the coaches' work for the program. The loss of coaching staff to other organizations that can offer higher salaries has been a challenge, especially given the high investment made in training and supporting these staff. However, program administrators regard the fact that their staff are highly sought-after as a mark of the quality of the program and the highly skilled individuals that they employ.

IX. Next steps for training

The North Carolina AHEC PSP hopes to implement a formal evaluation of its training program in the future. Staff members continue to update curriculum content to keep pace with changes in local, State, and Federal health care regulations and requirements.

X. Lessons learned

Training has grown in diversity and scope along with the program. The training strategy grew from a small-scale, predominately apprenticeship program at start-up to one that now has multiple training methods and components.

Coaches are as effective as the training and support they receive. Coaches are the means for pushing out new content and interventions to practices, and as such are the primary means of intervention for a PSP. Investments early and often in training and support of coaches are important to developing an effective coaching workforce and PSP.

It is easy to underestimate the costs of effective coach training. The process of coach training can be costly, and it is easy to underestimate the funding required to make that training effective. To be effective, coach training needs to be intensive and continuous. It also requires development of new training content on a regular basis, all of which requires funding and time.

Training content should be tailored to meet the learning needs of different students. Many individuals come to coaching as a second career. As a result, they bring a diversity of knowledge, skills, and experience. Coaches' existing knowledge and skills should be assessed before training starts, and training content should be adjusted to accommodate previous experience and to address gaps.

Apprenticeship in the practices that staff will eventually support is ideal. This allows the staff to build relationships with the practice and with his or her team members at the same time he or she is building skills.

In a team approach to coaching, practice coaches need to be proficient in their particular area of expertise but do not need to be proficient in every competency. Coaches should focus on building their skills in their area of expertise, be familiar with the areas of mastery of their fellow coaches, and be adept at engaging them on a facilitation team when that particular skill is needed. A training program's curriculum should allow for this type of differentiated learning and instruction.

Training programs should help coaches become proficient first in areas that are highly valued and immediately useful to practices and build skills in less urgent areas later. This helps coaches build self-confidence by giving them a way to be immediately useful and increases practice members' trust and interest in working with the coaches. This in turn supports future work to build quality improvement capacity.

The training curriculum cannot be static. New materials need to be developed regularly to keep practice coaches up to date with new regulations and programs. Training programs need a mechanism for tracking new developments and for training coaches in these areas in a timely manner.

Outside faculty are important resources for a PSP. Not only do they provide training to practice coaches, but they can also serve an important public relations function for the PSP. Engaging outside experts as faculty can bring desirable expertise and help build local credibility for the PSP.

This case study was developed as part of a contract funded by the Agency for Healthcare Research and Quality and was authored by:

Lyndee Knox, Ph.D., Director, LANet

Jesse Crosson, Ph.D., Senior Researcher, Mathematica Policy Research

Erin Taylor, Ph.D., M.P.P., Associate Director of Health Research and Senior Researcher,
Mathematica Policy Research

Appendix A: North Carolina AHEC PSP Training Program Partial Competency List and Target Proficiency Level

Describe: I know what this is and can describe it to others.

Explain/refer: I can explain this to others and refer them to reliable sources of more in-depth information than I can provide.

Demonstrate/apply: I apply this in my daily work; someone can observe me doing this.

Teach/facilitate: I teach this and facilitate others in its use.

Content area/topic/skill	Level
NC AHEC mission	1
Practice support program mission	1
Organizational structure	1
Funding	1
Criteria and standards by which program is evaluated	1
Partner organizations	1
Program work groups (e.g., data reporting, QI training, etc.)	1
Other QI approaches (LEAN, six sigma, etc.)	2
Motivational interviewing	2
Group medical visits	2
Access scheduling	2
NCQA application process	2
PCMH resources (CCNC Webinars, NCQA Webinars, PBWorks, Google)	2
NCQA 2011 standards and criteria	3
PCMH/MU core and menu measure crosswalk	3
Applying QI/EHR/REC/CMS/MU knowledge to PCMH consulting	3
Role of AHEC practice support consultant	3
Co-consulting (with other AHEC consultants, CCNC staff, etc.)	3
Practice recruitment and engagement (explaining program, executing agreements, etc.)	3
Practice assessment (readiness to change, key driver implementation scale [KDIS], etc.)	3
Planning and facilitating effective practice visits	3
Custom report writing, extracting clinical improvement measures data from EHR	3
Core resources (e.g., Dartmouth Green Book, IHI, Safety Net Medical Home Resources, etc.)	3
Practice coaching (e.g., water line model, change management, leadership, etc.)	3
Regional collaboration (e.g., sharing data, peer learning, collaborative meetings, etc.)	3
Setting post go-live goals and facilitating optimization process to achieve goals	3
EHR customization/optimization/reporting—MU and QI	3
MU gap analysis	3
REC practice milestones	3

Content area/topic/skill	Level
QI data (e.g., run charts, control charts, etc.)	4
Practice Support Program change package—general approach to improving clinical care promoted by NC AHEC Practice Support Program	4
Diabetes change package—clinical guidelines, improvement strategies, and measures specific to diabetes improvement	4
Asthma change package—clinical guidelines, improvement strategies, and measures specific to asthma improvement	4
Hypertension change package—clinical guidelines, improvement strategies, and measures specific to hypertension improvement	4
IVD lipid control change package—clinical guidelines, improvement strategies, and measures specific to IVD lipid control improvement	4
Tobacco dependence change package—clinical guidelines, improvement strategies, and measures specific to tobacco dependence improvement	4
Population management	4
Practice protocols	4
Planned care	4
Self-management support	4
Community resources	4
Team-based care	4
Model for improvement	4
Clinical improvement measures	4
QI tools (e.g., flow charts, check sheets, cycle time chart, balanced scorecard, etc.)	4
Basic project management	4
Meeting management	4
Clinical quality measures (CQM)	4

Appendix B: North Carolina AHEC PSP Core Competencies

Area 1. Program mission and methods

General overview

- ▲ North Carolina AHEC mission
- ▲ Practice Support Program mission
- ▲ Organizational structure
- ▲ Funding
- ▲ Criteria and standards by which program is evaluated
- ▲ Partner organizations
- ▲ Program work groups (e.g., data reporting, QI training, etc.)

Program systems, processes, and tools

- ▲ Clinical improvement data capture and reporting (www.ncipip.org) --> MyAHEC practice support
- ▲ PBWorks (northcarolinaahecdigital.pbworks.com/n/home)
- ▲ AHEC quality source (www.ahecqualitysource.com)
- ▲ REC data system (www.ncahecrec.net)
- ▲ REC Monday training calls
- ▲ Practice Support Program listserv
- ▲ MU office hours call
- ▲ AHEC consultant self-assessment tool
- ▲ CCME training modules
- ▲ Tutorial on REC Web site
- ▲ MOC Part IV credit process

Area 2. Clinical improvement consulting

Primary care systems

- ▲ Primary care office systems
- ▲ Payment, incentive, and recognition programs
- ▲ Practice types

Facilitative/empowerment consulting/coaching

- ▲ Co-consulting (with other AHEC consultants, CCNC staff, etc.)
- ▲ Planning and facilitating effective practice visits
- ▲ Basic project management
- ▲ Meeting planning and facilitation
- ▲ Practice recruitment and engagement (explaining clinical improvement program, executing agreements, etc.)
- ▲ Practice assessment (ACIC, key driver implementation scale [KDIS], etc.)
- ▲ Model for improvement (IHI Open School)
- ▲ Other QI approaches (LEAN, six sigma, CQM etc.)
- ▲ Custom report writing, extracting clinical improvement measures data from EHR
- ▲ QI data (e.g., run charts, control charts, etc.)
- ▲ QI tools (e.g., flow charts, check sheets, cycle time chart, balanced scorecard, etc.)
- ▲ Core resources (e.g., Dartmouth Green Book, IHI, Safety Net Medical Home Resources, etc.)
- ▲ Practice coaching (e.g., water line model, change management, leadership, etc.)
- ▲ Regional collaboration (e.g., sharing data, peer learning, collaborative meetings, etc.)
- ▲ Generic consulting
 - Facilitative/empowerment consulting/coaching
 - Co-consulting (with other AHEC consultants, CCNC staff, etc.)
 - Planning and facilitating effective practice visits
 - Basic project management
 - Meeting planning and facilitation

Area 3. Practice system redesign and innovation

- ▲ Chronic care model
- ▲ Practice Support Program change package—general approach to improving clinical care promoted by North Carolina AHEC Practice Support Program
- ▲ Diabetes change package—clinical guidelines, improvement strategies, and measures specific to diabetes improvement
- ▲ Asthma change package—clinical guidelines, improvement strategies, and measures specific to asthma improvement
- ▲ Hypertension change package—clinical guidelines, improvement strategies, and measures specific to hypertension improvement

- ▲ IVD lipid control change package—clinical guidelines, improvement strategies, and measures specific to IVD lipid control improvement
- ▲ Tobacco dependence change package—clinical guidelines, improvement strategies, and measures specific to tobacco dependence improvement
- ▲ Population management
- ▲ Practice protocols
- ▲ Planned care
- ▲ Self-management support
- ▲ Community resources
- ▲ Team-based care
- ▲ Motivational interviewing
- ▲ Group medical visits
- ▲ Access scheduling

Area 4. NCQA PCMH recognition

- ▲ NCQA 2011 standards and criteria
- ▲ PCMH/MU core and menu measure crosswalk
- ▲ NCQA application process
- ▲ Applying QI/EHR/REC/CMS/MU knowledge to PCMH consulting
- ▲ PCMH resources (CCNC Webinars, NCQA Webinars, PBWorks, Safetynet Medical Home)

Area 5. EHR incentive program consulting

- ▲ CCME training modules
- ▲ Tutorial on REC Web site
- ▲ Stage 1 MU
- ▲ Stage 2 MU
- ▲ Clinical quality measures (CQM)
- ▲ Setting post go-live goals and facilitating optimization process to achieve goals
- ▲ EHR customization/optimization/reporting—MU and QI
- ▲ MU gap analysis
- ▲ ONC milestones

Area 6. Practice management consulting

- ▲ Payment reform (e.g., value-based modifiers, bundled payments, ACO, physician compare—financial capacity and skills required, etc.)
- ▲ RVU analysis
- ▲ Benchmarking
- ▲ Coding/billing 101
- ▲ Business models for quality (e.g., CMS wellness exam, transitional care management, nurse visits)

